Attending Physician's Report

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Record of Examination

1. Patient's name Last	First	Middle	2. Date of Injury mo. day yr.	3. OWCP File Number	OMB No. 1215-0103 Expires: 10-31-99

4. What history of injury (including disease) did patient give you?

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? ☐ Yes ☐ No — ICD-9 Code

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

7. What is your diagnosis? — ICD-9 Code

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer) ☐ Yes ☐ No

9. Did injury require hospitalization? If no, go to item #13 ☐ Yes ☐ No	10. Date of admission mo. day yr.	11. Date of discharge mo. day yr.	12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25) ☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination mo. day yr.	15. Date(s) of treatment mo. day yr. mo. day yr. mo. day yr.	16. Date of discharge from treatment mo. day yr.

17. Period of total disability From mo. day yr. Thru mo. day yr.	18. Period of Partial Disability From mo. day yr. Thru mo. day yr.	19. Date employee able to resume light work mo. day yr.

20. Date employee is able to resume regular work mo. day yr.	21. Has employee been advised that he/she can return to work? ☐ Yes ☐ No	22. If yes, on what date was he/she advised? mo. day yr.

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #25 if necessary.)	24. Are any permanent effects expected as a result of this injury? If yes, describe in item #25. ☐ Yes ☐ No

25. Remarks

26. If you have referred the employee to another physician provide the following: Name	Specialty
Address	27. What was the reason for this referral?
City State ZIP	☐ Consultation ☐ Treatment

Signature

28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

Signature of Physician _____ Date _____

29. Name of Physician	30. Tax ID Number
Address	31. Do you specialize? ☐ Yes ☐ No
City State ZIP	32. If yes, indicate specialty

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION FOR LOSS OF WAGES OR PERMANENT DISABILITY CAN BE MADE TO THE EMPLOYEE.

IF YOU HAVE SUBMITTED A NARRATIVE MEDICAL REPORT OR A FORM CA-16 TO OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA 1500/OWCP-1500a.

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 1-32 ON THE FORM; AND
2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 17; AND
3. SEND THE FORM AND YOUR BILL TO:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

Public Burden Statement

We estimate that it will take an average 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

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